



WESTSIDE DEVILS CLUB REGISTRATION FORM 2010

Player Name.....
(Surname) (Given name)

Player Address
.....Suburb:.....Postcode:.....

Email.....Telephone:.....School:.....

Date of Birth..... Male /Female

Mother's Surname.....Given Name.....

Father's Surname.....Given Name.....

Do you agree to have your child's photo appear on our web site. Yes No

2009 Team Name:.....2009 Team Coach.....

CAN YOU ASSIST THE CLUB IN THE FOLLOWING AREAS?

Coaching Team Manager Working Bee
Training Committee Fundraising

MEDICAL CONSENT FORM:

Does your child suffer from any illness that the team coach should be aware of? YES/NO

Details:.....

Has injection been given for tetanus: YES/NO Is your child allergic to any medication?
YES/NO

Details:.....

Contact person/parent:..... Place of contact.....

Telephone:..... Mobile.....

In the event that none of the above can be contacted, I give permission for my child to receive medical treatment as indicated:

At the nearest public hospital

I give permission for my child to be taken for medical assistance by:

Private car: Taxi: Ambulance:

I give permission for my child to be given anaesthetic, in such emergency:

PARENT/GUARDIAN SIGNATURE:.....DATE:.....

OFFICE ONLY

Registration No.....